Department of Veterans Affairs
Office of Inspector General
June 2016 Highlights

CONGRESSIONAL TESTIMONY

Deputy Assistant Inspector General for Audits and Evaluations Tells House Subcommittee That Concerns Remain Regarding Records Disposition and Shredding of Claims-Related Documents at VA's Regional Offices.

Mr. Brent Arronte, Deputy Assistant Inspector General for Audits and Evaluations, testified before the Subcommittee on Disability Assistance and Memorial Affairs, Committee on Veterans' Affairs, U.S. House of Representatives, on two Office of Inspector General (OIG) reports on records disposition for veterans' claims-related documents. OIG found documents inappropriately scheduled for destruction at 11 VA Regional Offices (VAROs). The inappropriate destruction or mishandling of claims-related documents can lead to incorrect disability decisions and can affect the integrity of the Veterans Benefits Administration's (VBA) reported workload. Mr. Arronte highlighted OIG's historical work on this issue, which substantiated that VARO staff were not following VBA's policy on the management of veterans' and other governmental paper records, were not training employees, and were not filling records-management staff positions. Mr. Arronte acknowledged that VA has made some improvements in their compliance with records disposition over the years and that inappropriate document destruction will decrease with VBA's move to a paperless environment. He cautioned that there will be a need for oversight to ensure documents are actually scanned into veterans' electronic records and to guard against the mishandling of documents containing personally identifiable information. Mr. Arronte was accompanied by Ms. Dana Sullivan, Director of the OIG's San Diego Benefits Inspection Division. [Click here to access testimony.]

ADMINISTRATIVE INVESTIGATIONS

Alleged Preferential Treatment and Potential Misuse of Travel Funds, VBA, VA Central Office, Washington, DC

The OIG Administrative Investigations Division investigated and did not substantiate allegations that a VBA employee was given preferential treatment or that she misused VA travel funds to commute to and from VA Central Office. OIG found that the employee was competitively selected and promoted into a GS-15 position a year prior to requesting a downgrade to a non-supervisory GS-14 virtual position and that she was properly reassigned to an existing vacancy which allowed for 100 percent telework. Staffing and reassigning employees is at management's discretion as to what is best for the organization. OIG found no evidence that she received this downgrade as a result of favoritism or an abuse of position by any VBA official. In reference to her travel, OIG found that the employee's travel to VA Central Office, as confirmed by her supervisor, was essential to official VA business and a requirement of her position, as well as others working on the same team, to interact with VA contractor employees and VBA facilitators. [Click here to access report.]

OIG REPORTS

Evaluation of Reported Wait Times, VA Greater Los Angeles Healthcare System, Los Angeles, California

OIG evaluated the accuracy of reported wait times at VA Greater Los Angeles Healthcare System, Los Angeles, CA, for January and March 2015, at the request of Senator David Vitter. The first objective was to evaluate whether information presented in a February 3, 2016, letter from Secretary Robert A. McDonald to Senator Vitter (Secretary's letter) accurately represented wait times at the VA Greater Los Angeles Healthcare System. The second was to explain the discrepancies between reported wait times in the Secretary's letter and what CNN reported on March 14, 2015. The Veterans Health Administration (VHA) generates a number of measures that collectively provide a comprehensive view of appointment wait times. To avoid the perception of misrepresentation of wait times, it is imperative that VA, the media, and others clearly indicate both the source of the data and the type of wait time measure being referenced. OIG found the wait times reported in the Secretary's letter were generally consistent with VHA's historical wait time data. With respect to the January 2015 completed appointment wait times for new and established patients, OIG noted differences of less than 1 day between the two data sources. OIG concluded that those small differences are likely due to the fact that the information used in the Secretary's letter was from February 5, 2015, and wait time data were not finalized in VA's centralized data repository until February 14, 2015. With respect to the March 2015 completed appointment wait times for new patients for primary care, those data were consistent with VHA's historical wait time data. OIG found that discrepancies between information contained in the Secretary's letter and CNN's article were likely the result of (a) the CNN authors' inaccurate assertion that appointments and consults are synonymous and (b) the Secretary and CNN authors referenced different wait time measures. OIG made no recommendations. [Click here to access report.]

Access and Quality of Care Concerns, Phoenix VA Health Care System, Phoenix, Arizona, and Delayed Test Result Notification, Minneapolis VA Health Care System, Minneapolis, Minnesota

At the request of Congressman Tim Walz, OIG inspected the Phoenix VA Health Care System (VAHCS), Phoenix, AZ for allegations of wait times in the Emergency Department (ED), cleanliness, Allergy Clinic, VA Police Department, outpatient pharmacy services, and primary care provider (PCP) assignment. An additional allegation at the Minneapolis VAHCS in Minneapolis, MN involved test result notification. OIG substantiated the length of stay (LOS) patients experienced on a day in 2015 was the longest ED patients experienced from March 1, 2014, through March 31, 2015. The Phoenix VAHCS' ED median wait time (190 minutes) for the period reviewed did not exceed the VHA's LOS threshold. OIG determined an effective mechanism was not in place to recognize episodic, increased demand to adjust processes. OIG substantiated examination areas separated by curtains created a risk for inadvertent protected health information disclosure and patients brought to the Radiology Department from the ED were not always supervised. OIG identified an opportunity for improvement regarding timeliness of prescription delivery for discharged ED patients. OIG substantiated some Phoenix VAHCS treatment and public areas were

not clean. OIG determined Environmental Management Services' understaffing was a contributing factor. OIG substantiated Allergy Clinic staff did not consistently dispose of oral temperature probe covers properly. OIG could not substantiate the allegation that a VA police officer mishandled a veteran. OIG substantiated the Phoenix VAHCS pharmacy should have provided the patient a recommended medication or appropriate substitution. OIG substantiated the patient was not assigned a PCP at the Phoenix VAHCS; however, he was assigned a PCP at Minneapolis VAHCS. OIG substantiated Minneapolis VAHCS staff did not ensure the patient received magnetic resonance imaging (MRI) results within 14 days, as required. OIG made ten recommendations. [Click here to access report.]

Alleged Patient Safety Concerns, Miami VA Healthcare System, Miami, Florida
The Office of Healthcare Inspections conducted an inspection at the request of Chairman Jeff Miller, Committee on Veterans' Affairs, U.S. House of Representatives, and Chairman Mike Coffman, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, U.S. House of Representatives. The OIG team assessed allegations that the Miami VA Healthcare System (system), Miami, FL, lacked adequate patient safety policies and procedures to safeguard patients when they "come and go" from the Community Living Center (CLC) and whether additional safety measures could have prevented a patient's suicide. OIG did not substantiate the allegation that the CLC lacked adequate safety policies and procedures regarding patients' "comings and goings" in the CLC. OIG found that the system had policies and procedures addressing various aspects of patient safety in the CLC. However, OIG found that system staff did not consistently enforce certain policies and procedures when the patient did not comply with them. OIG could not substantiate the allegation that the system should have instituted additional safety precautions given the patient's past medical and mental health history. However, OIG identified additional potential suicide risk factors known to at least one staff member that were not documented or discussed in the CLC Interdisciplinary Team meetings. OIG also found that staff did not initiate an Integrated Ethics consult, which could have been done to assist them and the patient in making informed decisions and applying appropriate healthcare ethics standards regarding medical care, treatment, and patient autonomy. By failing to consistently enforce certain policies and procedures and initiate an Integrated Ethics consult, system staff missed opportunities to intervene with this patient. Although a system internal review addressed some specific issues pertaining to patient care, it did not reflect and document an in-depth exploration of possible event causes. OIG made four recommendations. [Click here to access report.]

Mental Health Service Concerns at the Knoxville VA Outpatient Clinic, James H. Quillen VA Medical Center, Mountain Home, Tennessee
OIG conducted an inspection at the request of Senator Lamar Alexander and Congressman John Duncan to assess allegations of mental health service concerns at the Knoxville VA Outpatient Clinic, Knoxville, TN, which is part of the James H. Quillen VA Medical Center (facility), Mountain Home, TN. OIG substantiated the allegation that facility managers did not have Peer Support Services (PSS) available to veterans at the Clinic for several years. OIG did not substantiate the allegation that the PSS Specialist

hired by the Clinic was expected to provide PSS related functions for groups hosted by the Knoxville Regional Mental Health Council (Council). OIG substantiated that patients were discharged from a non-evidence based post-traumatic stress disorder group without immediate PSS follow-up. OIG substantiated the allegation that facility managers delayed hiring a Veterans Justice Outreach (VJO) Specialist to service veterans in Knox County and surrounding counties. OIG did not substantiate the allegation that medication confirmation requests take 3–5 days for incarcerated veterans. OIG did not substantiate the allegation that facility and Clinic managers failed to uphold agreements with the Council regarding: (1) providing meeting space for the group hosted by the Council, (2) sponsoring PSS facilitator training for members of the Council, and (3) providing travel pay for Council group members. OIG recommended that the Facility Director improve processes for communicating with community-based consumer-run groups that provide mental health services to veterans enrolled at the Clinic and ensure the Clinic's VJO Specialist provides comprehensive services including outreach for veterans in Knox County and surrounding counties in accordance with VHA policy. [Click here to access report.]

Audit of Modular Ramps Purchased by the Malcom Randall VA Medical Center, Gainesville, Florida

In May 2015, Congressman Tim Walberg requested OIG review an allegation where the complainant alleged the Malcom Randall VA Medical Center (VAMC), in Gainesville, FL, purchased modular ramps that did not comply with Americans with Disabilities Act (ADA) standards. OIG substantiated the allegation. Specifically, for 20 of 33 (61 percent) purchase orders reviewed, staff did not consistently ensure ramps were ADA compliant prior to awarding purchase orders to vendors. Additionally, for all 33 purchase orders reviewed, staff did not perform follow-up to ensure installed ramps complied with ADA. OIG also measured six vendor-installed modular ramps and determined none of the six complied with ADA standards. As a result, OIG estimated staff made errors for modular ramp purchase orders totaling approximately $342,000 from August 2014 through March 2015. This occurred because the VAMC lacked effective controls including a quality review process, formal training program, comprehensive written procedures, and formal requirements for vendors to provide ADA-compliant ramps and measurements. OIG recommended the Director of the Malcom Randall VAMC enhance procedures and controls to help ensure modular ramps are installed in compliance with ADA standard. The VAMC's Director concurred with OIG's findings and requested closure of the recommendations based upon actions taken as a result of OIG's review. Although the VAMC partially addressed OIG's recommendations, additional actions are necessary. [Click here to access report.]

Review of VA's Guidance on Protecting Religious Beliefs

In the report to accompany H. R. 2029, Military Construction, Veterans Affairs, and Related Agencies Appropriations Bill, 2016, the House Appropriations Committee requested OIG review VA's guidance to ensure religious sensitivity. VA's religious tolerance guidance generally aligned with Federal laws and included policies that provided reasonable assurance of ensuring sensitivity to the religious beliefs of veterans and their families, and employees at VA facilities. However, as of February 2016, VA

was operating with eight policies governing the protection of religious beliefs that VA had not reviewed for recertification or rescission as required by VA policies. This included five from the National Cemetery Administration (NCA) and three from the VHA. Although OIG's review did not find evidence that VA's outdated guidance contributed to religious insensitivity, VA should have recertified or rescinded these eight policies. The length of time VA was past due in performing these actions ranged from about 14 months to approximately 22 years. VA had not updated these policies because NCA and VHA did not complete timely reviews to compensate for the time needed for drafting guidance and to obtain necessary staff concurrences. By updating guidance, VA will help mitigate future risks of religious insensitivity. OIG recommended the Interim Under Secretary for Memorial Affairs and the Under Secretary for Health recertify or rescind and replace religious tolerance guidance documents and develop mechanisms to ensure staff begin the process of updating guidance and compensate for the time needed to draft guidance and obtain staff concurrence. OIG also recommended the Under Secretary for Health provide a means to assist in obtaining timely concurrences. The Interim Under Secretary for Memorial Affairs and the Under Secretary for Health concurred with OIG's recommendations and provided acceptable corrective action plans. OIG will monitor planned actions and follow up on their implementation. [Click here to access report.]

Review of VHA's Alleged Manipulation of Appointment Cancellations at VAMC Houston, Texas

OIG received an anonymous allegation that leadership was instructing staff at the Michael E. DeBakey VAMC and its associated Community Based Outpatient Clinics (CBOCs) to incorrectly record clinic cancellations as patient cancellations. OIG found no evidence the VAMC Director instructed supervisors or staff to incorrectly record appointment cancellations. OIG substantiated that two previous scheduling supervisors and a current director of two CBOCs instructed staff to incorrectly record cancellations as canceled by the patient. OIG identified 223 appointments incorrectly recorded as patient cancellations during the July 2014 through June 2015 time frame. Of the 223 appointment cancellations, staff rescheduled 94 appointments (42 percent) beyond 30 days. For these 94 appointments, veterans encountered an average 81-day wait, which was 78 days longer than shown in the electronic scheduling system. OIG also found that wait times were understated about 66 days for 50 appointments (22 percent) when they were initially scheduled. These issues have continued despite the VHA having identified similar issues during a May and June 2014 system-wide review of access. These conditions persisted because of a lack of effective training and oversight. As a result, VHA's recorded wait times did not reflect the actual wait experienced by the veterans and the wait time remained unreliable and understated. OIG recommended the Veterans Integrated Service Network (VISN) 16 Director ensure the VAMC Director confers with VA's Office of Accountability Review; provides scheduling staff training; improves scheduling audit procedures; and takes actions when the audits identify deficiencies. The VISN Director did not agree with Recommendations 1 and 2 but OIG considered the VISN's decision not to take administrative action the responsibility of the Director. The VISN Director concurred with Recommendations 3 through 6 providing acceptable planned actions. Based on

the actions taken, OIG consider Recommendations 1 and 2 closed, and will monitor the implementation of the remaining recommendations until all actions are completed. [Click here to access report.]

Review of Allegation of Underutilized MRI Scanner in Waco, Texas
OIG received a Hotline allegation that a mobile Magnetic Resonance Imaging (MRI) scanner was underutilized, and represents a waste of taxpayers' funds. VHA purchased the scanner in 2007 for the Center of Excellence (COE) for Research on Returning War Veterans, Waco, TX. OIG substantiated the allegation the MRI scanner was underutilized, representing a waste of taxpayers' funds. VHA paid approximately $2.9 million for the MRI scanner and annual maintenance costs of approximately $200,000. OIG determined the MRI scanner was not used for approximately 64 of 81 months from July 2008 through March 2015. This occurred because: (1) COE leadership did not anticipate the extent to which environmental conditions affected MRI scanner images; (2) the scanner required evaluation, software upgrades and repairs to accomplish the type of research being conducted; and (3) COE did not have staff qualified to operate the scanner or approved research projects. COE demonstrated poor stewardship of the approximately $2.9 million purchase cost of the MRI scanner and approximately $1.1 million in maintenance costs during the 64 months it was not used. The COE began using the scanner again in April 2015, and OIG confirmed the COE was still using the scanner as of February 2016. Since the issues that delayed the COE from using the MRI scanner were resolved, OIG did not make any recommendations. The Under Secretary for Health concurred with OIG's conclusions concerning the MRI machine. The Under Secretary's response also indicated top researchers have joined VA and relocated to Waco to do research using the device. The Under Secretary's response also noted the MRI was upgraded and that the new leadership has revitalized the program and put the Center on a productive pathway. [Click here to access report.]

Audit of VBA's Compensation and Pension Benefit Payments to Incarcerated Veterans
OIG conducted this audit to determine whether VBA was adjusting compensation and pension (C&P) benefits payments timely for veterans incarcerated in Federal, state, and local penal institutions. Federal law requires VBA to reduce C&P benefits for veterans incarcerated for more than 60 days in a Federal, state, or local penal institution. VARO and Pension Management Center (PMC) staff did not consistently take action to adjust C&P benefits for veterans incarcerated in Federal penal institutions. Specifically, based on Federal incarceration data ranging from May 2008 through June 2015, VBA did not adjust veterans' C&P benefits, as required, in an estimated 1,300 of 2,500 cases (53 percent), which resulted in improper payments totaling approximately $59.9 million. Without improvements, OIG estimated VBA could make additional improper benefits payments totaling about $41.8 million for Federal incarceration cases from fiscal year (FY) 2016 through FY 2020. VARO and PMC staff also did not take consistent and timely action to adjust C&P benefits for veterans incarcerated in state and local penal institutions. Based on incarceration notifications received from March 2013 to August 2014—the most current data available at the time of OIG's audit—VBA did not

effectively adjust veterans' C&P benefits in an estimated 3,800 of 21,600 state and local incarceration cases (18 percent), which resulted in significant delays and improper payments totaling approximately $44.2 million. Without improvements, OIG estimated VBA could make additional improper benefits payments totaling about $162 million for state and local incarceration cases from FY 2016 through FY 2020. In total, OIG estimated improper benefit payments of about $307.9 million. In general, VBA did not place priority on processing incarceration adjustments because VBA did not consider these non-rating claims to be part of the disability claims backlog. Both VBA Central Office and VARO staff consistently reported that incarceration adjustments were not a high priority. OIG recommended the Acting Under Secretary for Benefits increase the priority of VBA's incarceration adjustment workload. The Acting Under Secretary for Benefits concurred with OIG's recommendations. Management's planned actions were responsive and OIG will follow up as required. [Click here to access report.]

Combined Assessment Program Reviews

In June 2016, OIG published three Combined Assessment Program (CAP) reviews and two summary reports containing OIG findings for the facilities listed below. The purpose of the CAP reviews was to evaluate selected health care facility operations. Topics reviewed may vary due to differences in services provided at each facility, the need to follow up on previous CAP findings, or the rotation of CAP review topics over time. The reviews covered the following nine activities:

(1) Quality, Safety, and Value
(2) Environment of Care
(3) Medication Management
(4) Coordination of Care
(5) Computed Tomography Radiation Monitoring
(6) Advance Directives
(7) Suicide Prevention Program
(8) Nurse Staffing
(9) Quality Management

VA Connecticut Healthcare System, West Haven, Connecticut
Jesse Brown VA Medical Center, Chicago, Illinois
Amarillo VA Health Care System, Amarillo, Texas
Combined Assessment Program Summary Report – Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2015
Combined Assessment Program Summary Report – Evaluation of Surgical Complexity Support Services in Veterans Health Administration Facilities

Community Based Outpatient Clinic and Other Outpatient Clinic Reviews
In June 2016, OIG published three CBOC and other outpatient clinic (OOC) reviews and one summary report containing OIG's findings at select CBOCs and primary care clinics that fall under the oversight of the parent facilities listed below. The purpose of the CBOC and OOC reviews was to evaluate four operational activities:

(1) Environment of Care
(2) Home Telehealth Enrollment
(3) Outpatient Lab Results Management
(4) Post-Traumatic Stress Disorder Care

VA Connecticut Healthcare System, West Haven, Connecticut
Jesse Brown VA Medical Center, Chicago, Illinois
Amarillo VA Health Care System, Amarillo, Texas
Community Based Outpatient Clinics Summary Report – Evaluation of Alcohol Use Disorder Care at Community Based Outpatient Clinics and Other Outpatient Clinics

CRIMINAL INVESTIGATIONS

Non-Veteran Owner Found Guilty at Trial of Conspiracy To Defraud the United States and Wire Fraud
A non-veteran owner of a Service-Disabled Veteran-Owned Small Business (SDVOSB) was found guilty at trial of conspiracy to defraud the United States and wire fraud. A VA OIG, Small Business Administration OIG, General Services Administration OIG, Army Criminal Investigation Command, and Naval Criminal Investigative Service investigation revealed that the defendant established a Massachusetts-based SDVOSB company in 2006 and recruited two disabled veterans as the company's straw owners for the sole purpose of obtaining Federal construction contracts set aside under the SDVOSB program. As a result of the defendant's false representations to Federal contracting officers that the company was owned and operated by those service-disabled veterans, the company was awarded more than $112 million in Federal contracts between 2006 and November 2010, of which $110 million were VA contracts.

Former VA Contracting Officer Sentenced for Receiving a Bribe
A former VA contracting officer was sentenced to 6 months' incarceration, 6 months' home detention, and 3 years' probation after pleading guilty to receipt of a bribe by a public official. A VA OIG and Federal Bureau of Investigation (FBI) investigation revealed that the defendant accepted bribes from VA contractors in exchange for ensuring that the contractors received continuous construction work at various VA campuses. The bribes received by the defendant included cash, two vehicles, airplane tickets, hotel stays, and professional football tickets totaling $105,741 and affected VA contracts worth nearly $27 million.

Former VA Contractor Sentenced for Providing a Gratuity to a VA Contracting Officer
A former VA contractor was sentenced to 3 years' probation and was ordered to pay a $5,000 fine after pleading guilty to providing a gratuity to a VA contracting officer. A VA OIG and FBI investigation revealed that after receiving VA contracts the contractor paid for the contracting officer and her friends to travel to Las Vegas for her birthday in 2008, 2009, and 2010. The gratuities included payment of airline tickets and hotel accommodations.

Muskogee, Oklahoma, VARO Employee Pleads Guilty to Theft of Government Funds
A Muskogee, OK, VARO employee pled guilty to theft of Government funds. An OIG investigation revealed that on three separate occasions the defendant fraudulently processed Chapter 33 education benefits using the account of a veteran who was not currently receiving education benefits. The defendant had the funds sent to a Green Dot card account that he opened in his brother's name. The loss to VA was $41,991.

Former Albany, New York, VAMC Hospice Nurse Sentenced for Drug Diversion
A former Albany, NY, VAMC hospice nurse was sentenced to 82 months' incarceration and 3 years' supervised release after pleading guilty to tampering with a consumer product and obtaining controlled substances by deception and subterfuge. An OIG and Food and Drug Administration Office of Criminal Investigation investigation revealed that the defendant stole oxycodone hydrochloride from syringes and replaced the contents with Haldol, an anti-psychotic medication. The investigation further revealed that the defendant may have inflicted pain and suffering on dying hospice patients by diverting their pain medication for his own use and replacing it with a drug that was subsequently administered by other nurses.

Fiduciary Sentenced for Theft and Other Charges
A fiduciary was sentenced to 48 months' incarceration and was ordered to pay $117,635 in restitution ($35,962 to VA beneficiaries) after pleading guilty to criminal mistreatment, aggravated theft, theft, money laundering, and personal income tax evasion. A VA OIG, Social Security Administration (SSA) OIG, and Oregon Department of Justice Medicaid Fraud Unit investigation revealed that the defendant, who was assigned to over 100 veterans and other non-VA beneficiaries, embezzled funds from numerous accounts.

Educational Program Vendor Enters Into Civil Settlement with Government
New Horizons Guam, an educational program vendor, entered into a civil settlement with the Government after the U.S. Attorney's Office, Civil Division, Territory of Guam, filed a complaint under the False Claims Act. The vendor has already made one payment of $90,000 and is required to make a final payment in the amount of $60,000 by the end of August 2016. An OIG and FBI investigation revealed that the company falsified information in order to obtain VA educational benefits for several veterans. The company verified that veterans attended and completed an Information

Technology program; however, many of these veterans were not aware they were enrolled in the classes or did not complete the classes. The loss to VA was $73,578.

Veteran Arrested for Mail and Bank Fraud
A veteran was arrested for mail and bank fraud. A VA OIG, U.S. Postal Inspection Service, SSA OIG, and local police investigation revealed that the defendant falsified information (including employment and income information) in order to obtain a $423,000 VA guaranteed home loan and then subsequently defaulted on the loan. The defendant also provided false information in order to obtain a vehicle loan and then created a scheme to remove the first lien from the vehicle title in order to resell the vehicle for $55,000 to a legitimate second vehicle dealer.

Former Roommate of Deceased VA Beneficiary Sentenced for Theft
The former roommate of a deceased VA beneficiary was sentenced to 2 years' probation and was ordered to pay restitution of $26,647 after pleading guilty to theft of public money. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited to a joint account after the beneficiary's death in December 2012. The defendant used the VA funds to pay her expenses.

Veteran Arrested for Menacing at Buffalo, New York, VAMC
A veteran was arrested for menacing following an altercation at the Buffalo, NY, VAMC. A VA OIG and VA Police Service (VAPS) investigation revealed that the defendant got into a verbal confrontation with a female veteran at the medical center and then pulled what was believed to be a pistol from his pocket and threatened to shoot the victim. The defendant then fled the scene and hid the weapon, which was recovered at the medical center and discovered to be a BB gun.

Three Veterans Indicted for Travel Benefit Fraud
Three veterans were indicted for false, fictitious or fraudulent claims against the U.S. Government. An OIG investigation revealed that for approximately 2 years the three defendants submitted false addresses to the Asheville, NC, VAMC in order to receive travel reimbursements to which they were not entitled. One defendant received $15,391 by claiming an address over 100 miles from the medical center, when in fact he lived only 8 miles away. The loss to VA was $39,549.

Veteran's Son Arrested for Theft of VA Equipment
The son of a veteran was arrested for commercial burglary, grand theft, and probation violation. An OIG and VAPS investigation revealed that the defendant stole two sets of video teleconferencing equipment worth $7,700 from the Martinez, CA, outpatient clinic. The equipment was stolen during two separate VA medical appointments the defendant attended with his father. Both sets of equipment were sold on eBay at large discounts. OIG's Kansas City Office recovered the stolen equipment. A search warrant at the defendant's residence revealed other stolen items and methamphetamine on his person.

Fugitive VA Employee Arrested with the Assistance of OIG
A VA employee was arrested at the Long Beach, CA, VAMC by the local police and with the assistance of OIG. The fugitive was wanted for insurance fraud.

MICHAEL J. MISSAL
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